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MEDICAID MANAGED CARE AND FQHCs:

EXPERIENCES OF PLANS, NETWORKS AND INDIVIDUAL HEALTH CENTERS

FINAL F&PORT

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EXECUTIVE SUMMARY

The growth in Medicaid managed care--especially the use of mandatory enrollment and other more restrictive practices--is creating new challenges and opportunities for federally qualified health centers (FQHCs) and other safety net providers. Medicaid managed care programs are changing the way FQHCs are paid, eliminating cost-based reimbursement, increasing competition for Medicaid patients, and redirecting Medicaid funds for access-enhancing services. FQHCs may face increased demand among the uninsured if financial pressures force other providers to reduce their levels of uncompensated care. On the other hand, managed care may also create opportunities for FQHCs to operate more efficiently and even gain financially because of strong care management practices. Little is known about how FQHCs are responding to and affected by these changes, and about the relative merits of different managed care participation strategies for health centers in varied market environments.

OBJECTIVES AND METHODS

This study, funded by the Health Resources and Services Administration's Bureau of Primary Health Care and conducted by Mathematica Policy Research, examined and compared different managed care participation strategies and experiences among FQHCs in eight U.S. markets. It focused on three participation strategies: (1) being part of an FQHC-owned or sponsored health plan, (2) being a member of an FQHC network, and (3) contracting individually with non-FQHC plans, and addressed four central questions:

- How are FQHCs responding to Medicaid managed care?
- Why are some deciding to form plans and/or networks?
- What factors contribute to the success of FQHC plans and networks?
- How are health centers faring under different participation strategies?

The findings are based primarily on site visits conducted in the spring of 1997 to four FQHC-sponsored plans, eight FQHC networks and 24 individual health centers in the following markets: Baltimore, Boston, Detroit, Miami, Minneapolis/St. Paul, Oakland, San Diego, and San Francisco. The analysis also incorporated market-level information from various secondary sources and operational and financial data from the Bureau of Primary Health Care for their grantees.

Both Medicaid managed care program characteristics and market characteristics influence FQHC strategies and experiences. More influential Medicaid program characteristics include the extent of mandatory enrollment in risk-based plans, policies governing payment of FQHCs, and procedures for enrollment and default assignment to plans and providers. Influential market characteristics include the overall competitiveness of the Medicaid market, the amount of Medicaid market share held by FQHCs, and the strength of state and local support for the uninsured.

Our fmdings give some indication for the impact of more advanced managed care programs on FQHCs. The Medicaid markets in 6 of the 8 study areas were quite competitive at the time of the study. Also, the Medicaid managed care programs being implemented in each of the study areas have more advanced features, including mandatory enrollment and capitated payment arrangements.

Roughly half of the study plans and networks were still developing and not yet fully operational during the study period. Hence, our findings regarding the effects of plan or network membership on health center outcomes are more tentative.

FQHC Managed Care Participation Strategies

Even those FQHCs that in the past resisted managed care now see participation as a necessity. However, only a handful of the health centers in our sample are currently willing to assume risk beyond primary care under their managed care contracts.

Health centers are choosing to participate in FQHC plans and networks, strengthening their ties with local hospital systems, and expanding their involvement in Medicare and commercial managed care contracts. Hospital partnerships have provided some FQHCs with needed capital for facility and information improvements as well as hospital care for the uninsured.

FQHCs join and sponsor networks to centralize contracting, to develop health center managed care skills gradually, and to gain access to contracts involving more risk and the potential for greater financial benefit.

FQHCs opt to form plans when they are willing to assume more financial risk in exchange for greater control over and access to savings from strong care management. Key assumptions that drive plan formation decisions are that health centers will contribute substantial numbers of Medicaid enrollees and manage care costs effectively.

We found very few differences in the attributes of study health centers that had joined a network, affiliated with or sponsored a plan, or contracted individually.

Experiences of FQHC Plans and Networks

Capital needs are a major concern for newer FQHC plans and those trying to expand into new areas or product lines. This problem is particularly acute for FQHC plans structured as not-for-profit entities.

Although the two more established FQHC plans hold substantial market share and have performed well to date, they--like the two newer plans--face increased pressures arising from reduced premiums and greater competition for Medicaid enrollees. Newer plans--especially those in more competitive markets--are likely to require special support in the form of higher rates, preferences in contracting, or favorable enrollment policies.

The provider networks for the two older FQHC plans include substantial numbers of non-FQHC providers. Both plans thought that more diverse provider networks have helped the plans to expand their enrollment and service areas, and to withstand more competitive market conditions.

The network approach appears to offer health centers significant advantages in more competitive markets, but developing and sustaining a network is difficult and requires significant resources and expertise. Networks are helping member health centers with managed care contracting and with centralizing information and managed care systems.

Network success appears to be tied to capable leadership and similarities in the size, FQHC status, managed care capabilities, and goals of member health centers. Interestingly, it appears that stronger networks are developing in market environments that are less supportive of FQHCs.

How Health Centers are Faring Under Managed Care

Many FQHCs have improved their facilities and operations to become more attractive to managed care plans and enrollees. Several have moved into newer and larger sites, also adding ancillary services and urgent care capabilities. Others have expanded their operating hours and/or after-hours coverage, several have improved the way walk-ins are handled, and many have trained their staff in managed care policies and procedures. Still, most of the health centers we visited need to upgrade their information and management systems to better support their involvement in managed care. This is especially important for health centers contracting with multiple plans--the norm among the study sample.

Most of the study health centers are experiencing significant financial and operational pressures related to managed care. Many have lost money under Medicaid managed care in recent years, forcing some to cut back on services or operating hours, and to seek additional support from foundations, local hospitals, and other institutions. Health center financial situations have worsened with the implementation of more aggressive managed care programs that have accelerated competition for Medicaid patients and lowered payment levels.

Nearly all the study health centers have experienced increases in the number and proportion of uninsured patients. Demand among the uninsured has increased for most at the same time that

revenues to offset the costs of this care are declining. Several have already had to limit the amount of care provided to the uninsured, and others are struggling to find the resources to meet growing uncompensated care costs.

The manner in which an FQHC participates in managed care (alone or as part of an FQHC plan or network) does not by itself seem to have influenced how they have fared to date, perhaps in part because many were in involved in FQHC plans or networks that were just becoming operational.

At this early stage, the more successful health centers appear to be those that are larger, with a secure market niche, led by people with strong managed care expertise, housed in adequate facilities and with solid systems, and/or supported by strong local programs for the uninsured.

POLICY IMPLICATIONS

Efforts to support FQHCs should be designed to strengthen health center competitiveness but also to protect their viability as safety net providers for the poor and the uninsured. Cost-reimbursement provisions have the potential to offset revenue shortfalls for FQHCs under Medicaid managed care; but reimbursement should be structured to encourage health centers to operate efficiently, and to avoid discouraging plans from contracting with FQHCs. By requiring plans to pay FQHCs a higher rate or to reconcile losses, states may unintentionally discourage plans from contracting with and/or directing enrollees to FQHCs. Rather, allowing FQHCs to reconcile directly with the state should ensure that FQHCs are not placed at a disadvantage with Medicaid-serving plans.

Financial pressures are inducing some FQHCs to partner with local hospitals as a means of survival and to sustain services to the uninsured. While these partnerships appear to offer health centers many advantages, they may also make it more difficult for health centers to operate as independent, community-run organizations.

FQHC plans are facing increased competition in the Medicaid market, which is making it more difficult for them to sustain historic levels of assistance to their affiliated health centers. As a result, health centers should be encouraged to become more self-reliant by improving their internal information and management systems and diversifying their managed care involvement.

Finally, FQHCs need continued--and expanded--support for uncompensated care. This component is growing for many health centers at the same time that cross-subsidies from Medicaid and other payers are disappearing.

I. INTRODUCTION AND OVERVIEW OF THE STUDY

This study, conducted by Mathematica Policy Research (MPR) for the Health Resources and Services Administration (HRSA), examined different managed care participation strategies among Federally Qualified Health Centers (FQHCs) in eight U.S. markets. It investigated the factors driving decisions about whether and how to participate, identified more and less successful efforts, and analyzed the influence of various organizational and environmental factors on outcomes for FQHCs and the entities they sponsor. We focused primarily on three managed care participation strategies: (1) being part of an FQHC-owned or sponsored health plan, (2) being a member of an FQHC network that plays an intermediate role between plans and providers, and (3) contracting on an individual basis with non-FQHC plans.

The remainder of this chapter describes the motivation for the study and its central research questions, the methods and data sources, and key limitations. Chapter II summarizes important features of the study markets; Chapters III and IV present our findings on FQHC plans and networks; Chapter V describes how health centers have fared to date and the changes they have made because of managed care; and Chapter VI highlights our conclusions and the policy implications of study findings.

A. STUDY MOTIVATION AND RESEARCH QUESTIONS

FQHC experiences and strategies under Medicaid managed care are of great concern for several reasons. In addition to playing a significant role in meeting the special needs of Medicaid populations, FQHCs are major safety net providers for the uninsured and underinsured, and many also operate special programs for people who are homeless and those with HIV/AIDS or substance abuse problems. Cost-based-reimbursement provisions under Medicaid introduced earlier this

decade have bolstered the capabilities of many FQHCs to serve these groups and reduced the extent to which grant funding and private donations subsidized below-cost Medicaid revenue. Medicaid now surpasses grants as the largest single source of revenue for most FQHCs.[1]

At a minimum, Medicaid managed care programs are changing the way FQHCs are paid, most dramatically in programs that eliminate cost-based-reimbursement. Although the new payment methods (e.g., capitation, bonus and other incentive programs) may help to encourage health centers to be more cost efficient, they also could leave health centers with higher uncompensated care costs. In addition, in today's environment FQHCs are facing increased competition for Medicaid patients from health plans and other providers, along with cuts in Medicaid financing of case management, transportation, and other access-enhancing support services provided by FQHCs. Finally, FQHCs may experience increased demand among the uninsured, particularly if other providers are forced to reduce their levels of uncompensated care because of pressures related to managed care. On the other hand, managed care has the potential to enhance FQHC performance by promoting greater efficiencies, improving coordination and quality of care, increasing Medicaid market share, and improving access for their patients to certain services or specialist providers.

FQHCs are engaged in various strategies to survive and prosper in environments dominated increasingly by managed care. Some FQHCs (either alone or with others) have formed or sponsored their own Health Maintenance Organization (HMO) or similar health plan.

As of September 1997, roughly 27 FQHC health plans were operational across the U.S. (Bureau of Primary Health Care, 1997). Compared with other managed care participation strategies, owning and/or operating a health plan involves greater financial risk, along with the potential for greater

[1] Many centers also participate in FQHC cost-based reimbursement under the Medicare program, though because of the demographics of most center users, this source constitutes a much smaller proportion of total revenue.

financial benefit. Others are participating in integrated service networks with other FQHCs, some of which have been supported by grants from HRSA (roughly 64 to date) and others that have developed without such support. These entities play an intermediate role between providers and managed care plans, fulfilling many functions ranging from contracting with managed care organizations to developing centralized administrative and operational systems. Some FQHCs have opted against either of these approaches and, instead, contract with managed care plans on an individual basis. Finally, a relatively small number have decided against any form of participation, although this approach is much less common in markets with more advanced Medicaid managed care programs.

In funding this study, HRSA's Bureau of Primary Health Care wanted to learn more about how FQHC-sponsored plans and networks are structured and about the strengths and weaknesses of these approaches for different types of health centers in different market environments. We were asked to pay special attention to the networks because less is known about these entities and because they are becoming more and more prevalent. Information on FQHC managed care participation strategies and what works best, where and for whom will help the Bureau to support health centers and ensure that their safety net role is sustained under managed care.

The study addressed four central questions:

- How are FQHCs responding to Medicaid managed care?
- Why are some deciding to form plans and/or networks?
- What factors contribute to the success of FQHC plans and networks?
- How are health centers faring under different participation strategies?

B. DESIGN AND METHODS

The study incorporated both qualitative and quantitative data from primary and secondary sources. Our approach built largely on site visits to FQHC plans, networks and individual health centers in eight markets across the U.S. Overall we visited 4 FQHC plans, 8 networks, and 24 individual health centers. In addition to information obtained during the site visits, we interviewed state and regional primary care association contacts and reviewed available literature for additional information about health center managed care involvement and market dynamics.[2] Finally, we obtained annual report data for 1993, 1995, and 1996 from the Bureau of Primary Health Care for the health centers they fund (22 of the 24 study centers receive federal primary care grants; the other two are FQHC look-alikes and not required to submit such reports).

Site visit interviews were conducted with plan, network and health center executives, using a semi-structured interview guide, tailored as needed based on background information collected prior to the visits. The visits at each site lasted roughly 3 hours and typically included interviews with 2-3 executives. The topics covered in interviews with FQHC plans and networks and with individual health centers are included in Attachment A to this report.

The following criteria were used to guide our selection of states and associated markets for the study, in order of priority:

- ***FQHC Managed Care Participation Strategies. The*** market needed to contain either an FQHC plan or network (or both), and at least one of the areas needed to include health centers that had decided not to participate in the plan and network options. BPHC also wanted us to select a larger number of networks, and to avoid FQHC plans being investigated in other BPHC-sponsored studies.

[2] Including research conducted by the Robert Wood Johnson Foundation-funded Center for Studying Health System Change, and by MPR for the Health Care Financing Administration, the Kaiser Family Foundation, and the Commonwealth Fund.

- ***Length of Time FQHC Plan Or Network Has Been Operating.*** ***We*** wanted to include some FQHC plans or networks that had been operating for several years or more.

- ***Availability of Secondary Research.*** Because the study's resources would not permit an extensive gathering of Medicaid and managed care market information, both current and historic, we selected areas where we would be able to draw on available market-level research conducted by MPR and its affiliated Center for Studying Health Systems Change.

- ***Level and Nature of Medicaid Managed Care Activity.*** We gave preference to areas with mandatory Medicaid managed care program(s) and/or significant Medicaid managed care activity, and at least some areas where Medicaid managed care had been operational for several years or more.

We used a two-step process for the actual selection of study markets and FQHCs. First we gathered background information and worked with BPHC to identify the states and associated market areas that met our selection criteria. Second, we selected the health centers based primarily on the manner in which they participated in managed care (with an FQHC plan, in a network, as an individual subcontractor, or not at all). Additional factors such as size, sophistication, and/or role in the local delivery system were considered to narrow down the list of health centers as needed.

We ultimately selected FQHC entities in eight markets:

- San Diego, San Francisco, and Oakland in California
- Baltimore, Maryland
- Detroit, Michigan
- Miami, Florida
- Boston, Massachusetts
- Minneapolis/St. Paul, Minnesota.

Each market contained an FQHC plan or a network, and 3 markets contained both types of entities. For each of the study plans and networks, we selected at least one and sometimes two health centers,

preferably including the health center(s) most involved in spearheading the FQHC plan or network effort. Table I. 1 shows the relationship between the plans, networks and health centers across the study markets. We have not named the individual plans, networks and health centers to protect their confidentiality.

C. STUDY STRENGTHS AND LIMITATIONS

This study obtained extensive information about FQHC managed care strategies and experiences in selected markets. Nevertheless, due to study limitations, caution must be used in generalizing the findings to other FQHC entities and markets. To start, the sites were not selected randomly and study resources were limited. While our sample is likely to be fairly representative of FQHC-sponsored networks, we visited only 4 plans (of the 27 currently operating) so these findings in particular are more limited. Furthermore, we were able to include only a few health centers that had opted against being involved in a plan or network, and in most markets we visited only a subset of the health centers involved with each plan and network effort.

Another limitation arises because in many of the markets FQHC plans and networks were still quite new. This limited our ability to examine and attribute outcomes and experiences to specific managed care strategies. However, we did examine health center characteristics and recent trends in key areas to assess how the study health centers have fared in general and the changes they have made in response to managed care, identify those facing more and less vulnerable situations, and to compare and contrast health centers across different managed care participation strategies.

TABLE 1.1

RELATIONSHIP BETWEEN STUDY PLANS, NETWORKS, AND HEALTH CENTERS

Market	Total Number of Health Centers	Number of Health Centers by Relationship to Study Plans and Networks		
		With an FQHC Plan	With an FQHC Network	With Neither
Baltimore[1]	3		3	
Boston[2]	3	3	3	
Detroit	3	1		2
Miami	4	1	2	1
Minneapolis/St. Paul	3		2	1
San Diego	4	4	4	
San Francisco	1		1	
Oakland	3		2	1
Total	24	9	17 (7 also with plans)	5

[1] Two FQHC networks were operating in this market; we visited 2 health centers affiliated with one and a third that was affiiated with the other.

[2] The health centers we visited in Boston and in San Diego were involved with both an FQHC plan and a network.

II. KEY FEATURES OF THE STUDY MARKETS

In this chapter we describe the Medicaid managed care programs and relevant market characteristics facing study FQHCs, networks and plans. We begin by identifying a subset of influential Medicaid program and market variables and describing how each could influence FQHC involvement and experiences under managed care. We then compare and contrast the study markets across these variables, providing some context for understanding the role of environmental forces in shaping the managed care strategies and experiences of the study entities.

A. MEDICAID MANAGED CARE PROGRAM CHARACTERISTICS

We identified five Medicaid managed care program characteristics that either influence the supportiveness of the Medicaid managed care programs or have some bearing on whether and how FQHCs participate in managed care. These characteristics and their potential effects include:

- ***Extent of mandatory full-risk contracting.*** In markets where enrollment in risk-based plans is mandatory there is more pressure on FQHCs and other providers to participate in managed care in order to retain their Medicaid patients.

- ***Duration andphase-in time for the managed care program.*** If Medicaid managed care operated on a optional basis prior to mandatory enrollment, FQHCs may have benefitted from a longer period during which to adjust to managed care payment and system requirements. Major program changes implemented quickly can disrupt FQHC operations, particulary for those lacking managed care experience and related infrastructure/systems.

- ***FQHC contracting protections.*** States may require plans to contract with FQHCs or give them special consideration or preferences if they do.

* ***FQHC payment policy***. Except when permitted under special demonstration waivers, states operating Medicaid managed care programs are required to reimburse FQHCs on a cost basis. States use different methods to meet this obligation: (1) building FQHC funds into the premiums paid to managed care plans and require plans to negotiate rates with FQHCs that account for these dollars; (2) paying FQHCs a subsidy on top of the rates received from managed care plans, or (3) allowing FQHCs to apply to the state for

cost reconciliation at the end of the year. Requiring plans to pay FQHCs higher rates can introduce incentives to direct enrollees to other providers.

- ***Distribution of enrollees among plans and providers.*** Managed care enrollment and default assignment rules influence the volume and types of enrollees directed to FQHCs and other safety net providers, influencing both the risk profile and size of their Medicaid patient base.

B. MARKET CHARACTERISTICS

The following market features influence the competitive position of FQHCs and whether and how FQHCs participate in managed care.

- ***Degree of competition in the marketfor Medicaid.*** Greater competition for Medicaid patients increases the pressure on FQHCs to maintain their share of the Medicaid market. The level of competition in a given market is influenced by a number of related factors, including: activity/saturation in other markets (commercial and Medicare), adequacy of Medicaid payment rates (influences the level of participation among private providers and plans), the number of Medicaid eligibles and Medicaid managed care penetration rates, and the number and strength of Medicaid-serving health plans in the market.

- ***FQHCs Medicaid market share.*** FQHCs that serve a larger share of the Medicaid population when they begin participating in managed care are likely to be in a stronger position to adjust to new payment methods, to absorb losses during the transition period, and to negotiate more favorable contracts with managed care plans.

- ***Programs for the uninsured.*** In markets with stronger state and local programs supporting care to the uninsured, FQHCs are less reliant on Medicaid revenues to help cover uncompensated care costs, somewhat mitigating the effects of Medicaid managed care on the ability of FQHCs to serve the uninsured.

C. COMPARISON OF THE STUDY AREAS

Table II. **1** and the following text summarizes and compares key Medicaid program and market features across the eight study areas.

TABLE II. 1

MEDICAID PROGRAM AND MARKET FEATURES OF STUDY AREAS

	BALTIMORE	BOSTON	DETROIT	MIAMI	MINNEAPOLIS/ ST. PAUL	SAN DIEGO	OAKLAND	SAN FRANCISCO
MEDICAID MANAGED CARE PROGRAM FEATURES								
Use of Risk-Based HMOs	All	25% (100% in future)	All (soon)	60%	All (soon)	All (soon)	All	All
Mandatory enrollment in risk-based plans	Mid 1997	Expected 1998	Mid-1997	Spring, 1997	Since 1990 (1983 for some areas)	Late 1997; New defaults starting 6/96	1997	1997
Competitive Bidding	Yes	No	Yes	Yes (then canceled)	No	Yes (not very selective)	Yes	Yes
FQHC Cost Reimbursement	No	From plans	State reconciliation	From plans	State reconciliation	State reconciliation	From plans	From plans
Requirements for contracting with FQHC	Yes	None	Limited	None	Yes	No	Yes, local initiative	Yes, local initiative
Default Provisions	Preference to plans based on application score	Default to PCCM; geographic and other criteria	Preference to plans based on application score	Default to PCCM (soon to HMOs also); geographic and other criteria	Not a big issue because most already in managed care; low default rates	Defaults to risk-based plans; geographic and other criteria	Local initiative: 20 percent to county; 20 percent to CHCs; and 60 percent to individual physicians	Discretion of the plans

TABLE II.1 *(continued)*

	BALTIMORE	BOSTON	DETROIT	MIAMI	MINNEAPOLIS/ ST. PAUL	SAN DIEGO	OAKLAND	SAN FRANCISCO
MARKET FEATURES								
Competitiveness of Medicaid Market	Moderate/High	Moderate	Moderate	High	Low	Moderate	Moderate	Low
Number of Medicaid Plans (mid-1997)	8	11	16	18	5	6	2	2
Medicaid MC penetration (mid-1997) [1]	0.35	0.25	0.80	0.29	0.41	0.33	0.73	0.80
Commercial penetration (7/1/96)[2]	0.34	0.44	0.13	0.53	0.44	0.38	0.57	0.50
FQHC role in Medicaid	Moderate, stable	Major, stable	Minor, declining	Minor, declining	Moderate, stable	Major, stable	Moderate, declining	Moderate, declining
State or local programs for the uninsured	Moderate (select populations)	Generous and expanding	Poor	Moderate, available to subset of FQHCs	Available but underutilized	Poor	Poor	Moderate (select populations)
OVERALL ASSESSMENT								
Supportiveness of environment for FQHCs	Less	More	Less	Less	More	Less	More	More

[1] The number of Medicaid-serving plans and Medicaid managed care penetration rates were derived from information provided by FQHC study entities during site visits conducted by the authors in the Spring of 1997.

[2] Source: The InterStudy Competitive Edge 7.1, Part III: Regional Market Analysis. Minneapolis, Minnesota: InterStudy Publications, 1997.

1. Full Risk Contracting

The Medicaid managed care programs in seven of the eight markets require or will soon require enrollment in risk-based programs for the AFDC and related Medicaid populations. Only Miami will maintain a substantial primary care case management (PCCM) component (where enrollees are assigned to a primary care provider but services are paid on a fee-for-service basis and there is no risk-sharing), although the state plans to assign fewer beneficiaries to the PCCM program in the future. Three other markets (San Diego, Detroit and Boston) are phasing out their PCCM programs (in Boston the transition may take longer). Thus, FQHCs in each study market face strong incentives to contract with risk-based plans.

2. Program Duration and Phase-in Time

With the exception of Boston and Minneapolis, Medicaid managed care programs in the other markets had recently changed. Programs in Baltimore, Miami, Oakland, San Diego and San Francisco had recently converted from voluntary to mandatory enrollment; PCCM programs were being eliminated in Detroit and phased out in San Diego; and a competitive bidding process was introduced to select plans in both Miami and Detroit (the Miami process was later challenged and voided because of problems with the state's premium-setting methods). In contrast, FQHCs in Boston have had more time to prepare for a new waiver program that will eliminate the PCCM option and expand Medicaid eligibility to additional low income groups. Because that program's start may be as much as a year away, FQHCs have had time to prepare and are "enrolling" the uninsured in a non-binding manner to solidify relationships with these patients before the competition heats up.

3. FQHC Contracting Protections

Although most of the states employ measures to ensure some level of contracting with FQHCs, plans are not required to assign members to the FQHCs and thus in reality these protections offer only limited support. In Baltimore and Minnesota, Medicaid plans are required to contract with "essential community providers," although this requirement is waived in Baltimore if the FQHC has the option of contracting with an FQHC-controlled plan. In Oakland and San Francisco, one plan is required to contract with traditional providers (rather loosely defined) and the other receives "points" in the contracting process if they do. Similarly, plans in Detroit and San Diego were awarded a small number of additional points in the competitive bidding process if they contracted with FQHCs.

4. FQHC Payment Provisions

In theory, health centers in all but one of the study markets are still eligible for cost-based reimbursement under managed care, but most have experienced some problems with the reimbursement process. In four of the markets the state builds the FQHC funds into premiums paid to the plans and then expects FQHCs and the health plans to negotiate "reasonable" rates. In one market that approach has worked fairly well to date because most enrollment has been with an FQHC plan that willingly paid FQHCs an enhanced rate (although not cost-based); the situation may worsen as enrollment with non-FQHC plans expands. Channeling payments through the plans has caused problems in the other three markets. In two markets, the requirement to pay FQHCs a higher rate has given health plans an incentive to avoid contracting with and/or assigning enrollees to FQHCs; in the other, FQHCs are not even pushing plans for a higher rate because they fear this type of response. The outlook is somewhat brighter in the three markets where health centers are still able to apply to the state directly for reconciliation. However, even in these markets health centers

may still wait up to several years for these payments to materialize. Also, direct reconciliation is only being maintained during a transition period, after which health centers will need to deal solely with the plans. One unintended consequence of the state reconciliation approach is that it may provide health plans with an incentive to pay FQHCs artificially low rates if they know the health centers will be "made whole" by the state.

5. Default Assignment

In most of the markets the process for assigning enrollees to plans and for making default assignments was still evolving or was expected to change in the near future. All of the markets were using or planning to use a central enrollment broker to manage the enrollment and assignment process. In Miami and Boston, default assignments had historically been to PCCM providers, but in the future people will also be assigned to risk-based plans. In both Baltimore and Detroit, plans that scored higher in certain areas during the application process are supposed to receive higher numbers of default assignments. In Oakland and San Francisco, the central enrollment broker assigns beneficiaries to plans but the plan is responsible for assignment to the primary care provider. Because the plans must pay FQHCs higher rates, they are reportedly assigning fewer enrollees to FQHCs. In Oakland, FQHCs have lost market share because new default assignment rules favor private physicians over other types of providers. In other markets health centers report that the assignment process is slow and/or based on inaccurate data, which probably affects both FQHCs and other providers similarly.

6. Competition in the Medicaid Market

We classified the study markets into three categories with respect to the level of competition in the Medicaid managed care market at the time of our visits: more, moderate, and less competitive.

More competitive ***(Miami].*** In Miami, Medicaid fee-for-service payment rates increased a few years ago, particularly for obstetric care, such that payment levels for a delivery are now reportedly above private sector levels. Higher payment rates translated to higher managed care premium payments, encouraging participation among plans (the Miami Medicaid market includes 18 health plans) and their contracted providers. Managed care penetration rates are also high in both the commercial and Medicare markets. This saturation in other markets combined with high Medicaid payment, a large number of Medicaid eligibles, and moderate levels of HMO penetration, increases the relative attractiveness of Medicaid as a source of revenue to plans and providers.

Moderately competitive (Baltimore, Boston, Detroit, Oakland, San Diego). Like Miami, Baltimore and San Diego are characterized by a large number of Medicaid managed care eligibles and moderate Medicaid HMO penetration levels, however, the low payment rates in these two markets make them less competitive than Miami. The Medicaid market in Detroit is less competitive than Miami because 80 percent of the Medicaid population is already enrolled in an HMO or risk-based plan; furthermore, despite the large number of competing plans, the market is dominated by a few major players. In Oakland, Medicaid is a relatively attractive payer and the program has enjoyed strong provider participation from the private sector historically; however, the two-plan model limits competition to two plans. Although the Boston Medicaid market might otherwise be considered less competitive, a proposed waiver program has stimulated increased competition because it will increase the pool of Medicaid eligibles directed to risk-based plans.

Less competitive (Minneapolis, San Francisco). The Medicaid program in Minneapolis is dominated by a few plans which have enjoyed stable enrollment for a number of years. In San Francisco, the small number of Medicaid beneficiaries eligible for managed care participation **(50,000)** and the 2-plan model limit the amount of competition in the Medicaid market.

7. Role of FQHCs in the Medicaid Market

Relative to other Medicaid providers, FQHCs in Detroit and in Miami have lost substantial Medicaid market share and lack much clout in negotiating contracts and/or rates with plans. In contrast, FQHCs in Boston and in San Diego are positioned much better with substantial market share. In the other markets, the position of FQHCs is similar to other Medicaid providers, suggesting that FQHCs in these markets face neither an advantage nor a disadvantage in terms of Medicaid patient retention.

8. Programs for the Uninsured

Baltimore, Boston, Miami, Minneapolis, Oakland and San Francisco each have programs of some type to fund care for the uninsured, whereas there are no formal programs in Detroit and San Diego. The situation in Boston is the most generous and comprehensive. In Miami, state and local funds are dedicated to indigent care but directed to only a subset of the area's FQHCs. In San Francisco and in Baltimore the funding is targeted to specific populations (in Baltimore, for example, there is a program for children and another program for people with AIDS). In Minneapolis, an expansion program for low income persons provides insurance for a small premium, but the program is reportedly under-used.

9. **Overall Supportiveness of the Market Environment for FQHCs**

Based on the various features outlined above, along with a consideration of the historic nature of state and local support for FQHCs, we characterized each market as being more or less supportive of FQHCs. The study FQHCs operating in what we deemed to be more supportive environments are those in Boston, Minneapolis/St. Paul, Oakland, and San Francisco. In contrast, Baltimore, Detroit, Miami and San Diego were judged to be less supportive environments for FQHCs. The

environment, however, does not dictate or determine FQHC participation or experiences with Medicaid managed care. Rather, the Medicaid managed care and market environment provides a context for assessing FQHC participation strategies and the role that environmental forces may play in these decisions.

III. FQHC HEALTH PLANS

Health plans started by FQHCs were either operational or hoping to be operational in four of the study markets. Two are more established plans that currently dominate the Medicaid market in the study areas but are facing increased competition from recent Medicaid managed care reforms. It is too early to predict how the two newer plans will fare, but they clearly face significant challenges getting started in more advanced managed care markets. In this chapter we describe and compare structural and operational characteristics of the four plans, discuss the reasons for their formation, and describe health center views of their benefits and drawbacks. We conclude by offering lessons learned for other FQHC plans. We were limited in our ability to characterize more successful plans because only two of the plans were fully operational at the time of our visits.

A. PLAN CHARACTERISTICS

Basic features of the four plans are summarized in Table III.1 and described below. In general, the four plans share many common features, although the two more established plans differ from the newer plans in a few key areas.

Start Date and Licensing Status. Two of the plans became licensed non-profit HMOs in the mid-l 980s, while the other two are just starting out. At the time of our visits neither of the newer plans were operating in the study markets, but one was operational in several other counties within the state. Three of the plans are licensed HMOs, but two have been given waivers that exempt them from commercial enrollment requirements.[1] Only one of the four plans has a significant number of

[1] The requirement that Medicaid members can comprise no more than 75 percent of the plan's total enrollment.

TABLE III.1

CHARACTERISTICS OF FQHC PLANS

VARIABLE	NEW	ESTABLISHED
Start date (HMO)		
1986		2
1996	1	
Pending	1	
Type of license		
HMO	1	
Prepaid Health Plan	1	
75-25 commercial-Medicaid enrollment rules		
Waived	2	
Not waived		
Tax status		
For-profit	1	
Not-for-profit	1	
Founders/Partners		
Group of FQHCs	2	
Single FQHC		
FQHC Governing Role/Voting Share		
Less than 50 percent		
50 percent		
90 percent or more	2	
Service area		
Statewide	2	
county		
Total enrollees		
None	1	
10,000 to 20,000	1	
40,000 to 60,000		2
Medicaid market share in study market (risk-based plans)		
None (not operational)	2	
30 to 40 percent		1
60 to 70 percent		1

TABLE III. 1 *(continued)*

VARIABLE	NEW	ESTABLISHED
Accredited		
Yes		
Pursuing or plan to pursue	2	2
Percentage of plan enrollees assigned to FQHC primary care providers		
60 to 70 percent		2
100 percent	2	
Capitation of FQHCs		
Primary care only	2	2
Specialty and/or hospital care		
FQHCs held at risk for financial losses outside of primary care	0	0
Surplus sharing for specialty and hospital care	2	2
Supportiveness of environment for FQHCs		
More		1
Less	2	1

non-Medicaid enrollees (roughly 25 percent); another has a tiny number (12) of commercial enrollees but expects this to grow with its recent push to target smaller employers. One of the two newer plans was still awaiting final approval of its license to operate as a Medicaid-only prepaid health plan that will take on full risk like an HMO but not have to meet some of the other requirements of a regular HMO. In addition to dealing with substantial delays in the application process, this plan's progress has been impeded by significant turnover at the senior management level. Since it was formed in mid-1995, two executive directors have been replaced at least in part because of performance problems. Although none of the plans are currently accredited, all are either in the process of or planning to secure NCQA accreditation in the future.

Both of the older plans started by operating under local risk-based managed care programs for the indigent prior to becoming licensed Medicaid-serving HMOs. Plan leaders thought that this gave them a valuable edge by developing their skills in managing the care of more challenging populations. In addition, the older plans faced much less competition from other plans during the start-up and early operational periods, allowing them to build their enrollment base, provider networks and management infrastructure more gradually. The two newer plans face greater challenges starting at a time when mandatory enrollment is being implemented quickly and Medicaid service areas already contain established health plans with substantial enrollment and name recognition.

Ownership/Governance. ***Three*** of the plans were started by a group of FQHCs or a coalition representing them, with investment in and influence over the plan shared fairly equally among participating health centers. The other plan, however, was started by a single large health center and, although the plan contracts with nearly all the other FQHCs in the county, the founding health center

has historically played a more dominant role in the governance and operations of the plan. This health center contributed capital in the plan's early days, and information management and other expertise over the years; until about a year ago, the plan and the health center shared the same corporate offices and many of the same board members and administrative staff Despite this close relationship, the health center has no legal tie to the plan's assets (or liabilities) beyond its involvement as one of the plan's largest primary care providers. During the past year or so the two organizations have separated their corporate offices and most of their overlapping staff, in part because of state and federal pressure to eliminate any actual or apparent conflicts of interest. Tensions over financial and risk-sharing arrangements have added further distance between the two.

Only one of the plans established itself as a for-profit entity; for this plan, equity interest is currently shared among the 17 participating health centers, each of whom contributed equal amounts of start-up capital. The others decided against this approach primarily because of concerns about the negative image of for-profit entities. Ironically, the one plan that decided in favor of the for-profit approach did so despite fairly intense negative publicity surrounding for-profit plans involved in Medicaid scandals. This plan decided the potential benefits outweighed these concerns, namely that (1) FQHCs would have greater control over plan surpluses, and (2) it would be easier to sell the plan if that became advisable.

Although the not-for-profit plans do not have owners, per se, FQHCs influence plan operations and the use of surplus earnings through their role in plan governing boards. Whereas the governing boards for the two newer plans are comprised mainly of FQHCs, non-FQHC members comprise a substantial proportion of the boards for the two older plans. One of the more established plans recently merged with a large health plan because it needed to expand quickly and lacked the

necessary capital for expanding their provider networks and making operational improvements at both the plan and the health center level. Under the new arrangement, the proportion of board positions held by FQHCs was expected to decline from 60 to 30-45 percent. While the outlook for this plan is hard to predict because the merger was still unfolding, plan and health center representatives both were optimistic that the new entity will remain supportive of FQHCs and may even improve some long-standing limitations in the FQHC plan's information/reporting and other operational systems. FQHCs currently hold 50 percent of the board positions for the other more established plan. Although FQHCs currently dominate the provider networks and governing boards for the two newer plans, their boards may diversify as the plan networks expand and evolve over time.

Medicaid Service Area and Market Share. All but one of the plans operates or expects to operate statewide; the other operates in only one county. Both of the older plans are the largest Medicaid-serving plans in the study areas, with 30,000 and 55,000 Medicaid enrollees--which translates into market shares of 33 and 66 percent respectively. Both of the newer plans are phasing in operations on a county-by-county basis. One has roughly 12,000 enrollees spread over 4 counties, while the other had not enrolled anyone at the time of our visit. The former plan was unsuccessful in its bid to operate in the study area, which is the state's most densely populated Medicaid region, an area that has already converted to mandatory enrollment and which has many established Medicaid-serving plans.[2] The other new plan hopes to operate eventually in the study area but will begin in several smaller and less competitive markets.

[2] The bid was rejected reportedly because the state deemed its rates (which included a supplement for FQHCs) to be too high.

Role of FQHCs in Plan Provider Networks. Both of the older plans contract with nearly all the FQHCs in their service areas but they also contract with a substantial number of non-FQHC primary care providers. The newer plans currently contract only with FQHCs for primary care, but in the more competitive study areas the plans had each been successful in contracting with only one FQHC; the others (4 in each) had either opted to go with a network or to contract with multiple health plans on their own.

Facing increased competition, particulary for Medicaid enrollees, both of the more established plans are expanding their provider networks to include increasing numbers of non-FQHC primary care providers. One plan is accomplishing this through a merger with another large plan. The other more established plan has expanded its provider network largely by contracting with larger physician groups and Independent Practice Associations (IPAs). This plan has grown to favor contracts with larger groups and IPAs because these organizations are prevalent in their service area and they tend to require less support from the plan than smaller groups and FQHCs. One consequence of the network expansions, however, is that FQHCs in both markets are facing increased competition from other providers, leading many of them to pursue contracts with additional plans. While the two newer plans expect FQHCs to be the dominant if not the sole providers of primary care initially, it is likely that both plans will eventually need to add non-FQHC primary care providers as they expand their service areas and increase enrollment.

Plan leaders noted that many of the FQHCs they contract with have limited capabilities for conducting utilization review, provider profiling, and cost/payment analyses related to managed care. Although the plans have generally supported the health centers in these areas to the extent feasible, they worry **about their ability to do so cost effectively in increasingly competitive markets. In both**

markets with more established FQHC plans, it appears that managed care-related support from the FQHC plan has reduced the pressure on health centers to develop this capacity themselves.

Provide Payment Arrangements. Payment arrangements between the plans and FQHCs are strikingly similar? All four plans capitate FQHCs only for primary care, which sometimes includes obstetric and basic laboratory services. The two older plans have a few contracts for specialty care that involve capitation, but for the most part the plans all pay for specialty care on a fee-for-service basis and hospitals are paid per-diem or DRG-based rates. Health centers are held at risk financially only for costs associated with primary care; none of the plans currently put health centers at risk for losses tied to specialty or hospital utilization. Like other contracted primary care providers, however, FQHCs do share in a percentage of savings from specialty and hospital pools.

Most of the health centers were content to limit their risk to primary care, and they had similar arrangements with other types of plans. But in one market several health centers would prefer to take on full professional risk! In this market the FQHC plan's unwillingness to pass on more risk has led its founding health center to spearhead efforts with the local FQHC network to seek better contract terms with other plans.

All four plans reportedly pay FQHC providers primary care capitation rates that are higher than rates paid by other Medicaid-serving plans, but payment levels have declined recently and are expected to decline even further in the future. In two markets the plans receive higher premium payments from the state because of their status as an FQHC-focused plan. However, state-paid

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[3] For one of the newer plans, we refer to the arrangements they expect to have with providers once their license is approved.

[4] Under a full professional risk contract, the contractor assumes all risk associated with physician and other medical services (but not for hospital and other institutional costs).

premiums to all plans have started to decline in both of these markets, which has already resulted in lower capitation payments to providers and reductions in surplus payments from specialty and hospital pools. Premiums were also expected to decline for the two newer plans in the near future, adding to their challenges in getting started and becoming self-sufftcient.

In two markets health centers must reconcile directly with plans if their negotiated payments do not cover their costs. The health centers we visited in these markets have not requested additional payments from plans when they have experienced losses; for some, surplus and incentive payments have compensated for the losses, while for others information system problems have prevented the health center from documenting their losses clearly. In the other two markets, FQHCs can still apply directly to the state for cost-based reconcilation if their managed care payments fall below costs.[5] Health centers in one market had applied for such payments but the outcome was still unclear.[6]

B. REASONS FOR PLAN FORMATION AND HEALTH CENTER PARTICIPATION

A central factor in the decisions to form each of the plans was the desire to protect and enhance the role of health centers in serving the Medicaid population and other insured patients. The plans were all formed in part because risk-based Medicaid managed care programs were expected to become mandatory in the near future. Participating health centers hoped that by forming an FQHC-

[5] In both cases Primary Care Associations convinced the state to continue direct reconciliation with FQHCs during a transition period (eliminated within a year in one market and phased-out over 4 years in the other).

[6] The state reportedly wants to include risk pool surplus and other incentive payments as compensation when computing net income or losses under managed care, whereas the health centers are arguing that only capitation and fee-for-service payments should be included.

focused plan they would be able to retain more of their Medicaid patients and better control over their care, in addition to having the potential to access a greater share of the savings from strong care management. Key assumptions about plan viability included that FQHC providers would (1) contribute significant numbers of Medicaid patients, and (2) deliver primary care in a cost effective manner that would result in reduced spending on specialty and hospital care. In one market the plan approach was also viewed as giving health centers better access to specialty providers.

Many of the health centers we visited had either postponed or decided against joining or forming an FQHC plan, for the following reasons:

- ***The PCCM Program Provided a Safe Haven.*** Several health centers in one market resisted contracting with the FQHC plan for many years because their patients could still access the health center through the primary care case management (PCCM) option. Adding to their hesitation was the fact that the FQHC plan was closely allied with and perceived as favoring a particular health center.

- ***Start-up Costs Too High and Likely to Increase. Several*** health centers said they were concerned that the initial capital investment required by the plans was too steep and, at the same time, that the funds would probably still not be adequate to cover necessary start-up costs.

- ***Competition from Established Plans Too Great.*** Many worried that the FQHC plan would not be able to compete successfully against large and established HMOs in their market. One health center executive emphasized the marketing challenge facing new FQHC plans: "why would someone join the FQHC plan when they could pick one of the big ones they see advertised all the time?'

- ***Statewide Plans Less Able to Address Local Dynamics.*** In the two markets with fledgling statewide FQHC plans, health centers were concerned that the plan would not be able to focus adequately on delivery system dynamics and patient needs in the largest cities, which they believe differ significantly from other regions in the state. Instead, these health centers decided to join local FQHC networks to negotiate managed care contracts and build support centrally for key administrative and operational functions.

- ***FQHCs are Better Off Sticking to their Role as Primary Care Providers. Related to*** concerns about competition and capital requirements, many health centers believed the plan option would be too risky and that the health centers would be better off securing their role as primary care providers. In one market the health centers are instead solidifying partnerships with local hospital systems and their affiliated plans.

Plan membership was uncontroversial in one of the markets, in part because area health centers believed mandatory managed care was imminent (although implementation actually took nearly 10 years), the FQHC plan had few real competitors until recently, the plan and the health centers shared similar expectations about appropriate levels of risk-bearing, and the plan's payment rates and incentives were considered fair.

C. LESSONS FOR OTHER FQHC PLANS

Because we visited such a small number of fully operational plans, we were unable to characterize the attributes of more successful plans. Rather, the following provides insights shared by FQHC plan and health center representatives that may help health centers thinking about forming a plan in other markets.

1. FQHC Plans Should Give Strong Consideration to Including Non-FQHC Providers in Their Networks

Both of the more established plans have decided to include a substantial number of non-FQHC providers in their networks. One plan's strongest recommendation to health centers was that they not ally exclusively with other FQHCs. More diverse provider networks were thought to help by (1) expanding the plan's service area and capacity for new enrollees; (2) attracting enrollees that have relationships with or prefer non-FQHC providers; and (3) possibly reducing the amount of support required from the plan, if the provider groups and IPA's have stronger management and

administrative resources and capabilities. One drawback, however, is that the plan may lose its preferred status as an "FQHC plan" by contracting with greater numbers of non-FQHC providers. But this would affect only those plans that had received special support or preference in the past.

2. FQHC Plans Face Difficulties Accessing Capital

Insufficient access to capital was reported to be a major problem for two of the non-profit plans, and most non-profit FQHC plans operating in more competitive markets would likely face this problem. One of the newer plans discovered that initial projections of capital needs seriously underestimated the amount required to carry the plan through the start-up period. Although the plan was expected to be self-sufficient financially within one year, its start-up costs have been much higher than expected because (1) it is taking longer to negotiate successfully with hospitals, (2) the volume of enrollees from health center members has been much lower than expected, and (3) the health centers are not managing care as aggressively and cost effectively as planned. At the time of our visit this plan was consumed by worries about capital and very concerned about the plan's future. The other plan reported that the lack of capital for expansion and operational improvements played a major role in its decision to merge with a large deep-pocketed health plan.

3. The Information and Operating Systems of Many FQHCs are not Adequate to Support Managed Care

The three operating health plans each noted that many of their FQHC providers lack adequate managed care systems and procedures. Concerns about health center information systems were common. Many health centers are unable to analyze and combine utilization and cost information for their managed care contracts, seriously undermining their ability to assume risk safely under these

contracts, and to negotiate fair compensation from plans and/or the state. A representative from one of the newer plans complained about the "mindset" of some FQHC physicians, adding that some believe "more care is always better," which isn't compatible with managed care principles. All three operational plans thought FQHCs could be stronger in managing hospital care. Because of these limitations, FQHC plans in our study have been providing a substantial amount of support to FQHC providers. Although in most cases the health centers have welcomed such support, and not all of them require it, some health centers have grown to depend on it. These health centers are more vulnerable because the FQHC plan may not be able to sustain such support, and because other plans are more likely to expect the health center to have these system capabilities.

4. **Special Support May be Needed by New FQHC Plans Competing in Established Managed Care Markets**

Both of the older plans became licensed HMOs at a time when enrollment in Medicaid managed care programs was still voluntary and there were few plans competing for Medicaid enrollees. Although both plans now face much greater competition, their positions are reasonably secure because they have already acquired substantial market share. In contrast, the two newer plans face major obstacles as they try to establish themselves in larger and more established managed care markets. Start-up plans also face more difficulty entering markets that have already transitioned to mandatory enrollment, particularly when the program's enrollment and default assignment rules favor larger or more established players (as in states that base default assignments on a plan's overall service or network capacity). Perhaps these newer statewide plans will do better in areas where they enrollment in Medicaid managed care is still voluntary and/or where there are fewer strong competitors. It seems unlikely, however, that a newer FQHC plan would be able to succeed in some

of the more competitive Medicaid markets without substantial support from government or other outside sources. This support could be financial--i.e., start-up capital and/or enhanced premiums--or aimed at enrollment, with special preferences awarded during contracting and/or during the enrollment and default assignment process.

IV. FQHC NETWORKS

We visited a total of 8 FQHC networks in 7 markets (one market had two networks). All are relatively young, evolving organizations that are still sorting out their structures and operations. and identifying desirable affiliations and business opportunities.[1] They provided us with insights into the varying pressures and opportunities available to health centers seeking collective strategies for participating in managed care. This chapter describes the structural and operational features of the study networks, and their managed care strategies, motivations for forming, strengths, weaknesses and future outlook.

A. NETWORK CHARACTERISTICS

There appears to be no single formula for network development. Each network is a distinct organization, developed out of and structured to address a variety of local market forces, opportunities, and historic affiliations and attitudes. What works in a one market or for one group of health centers may neither work nor even be an option in another market or for another group of health centers. As shown in Table IV.l, the study networks vary across a number of structural and operational dimensions. In the following sections we highlight how these varied structural and operational features appeared to influence a network's preparedness to operate in increasingly competitive environments.

[1] One network was no longer operational at the time of our visit, although some of its former members are thinking about reviving collective strategies because they have been unable to secure favorable managed care contracts on their own.

TABLE IV. 1

FEATURES OF STUDY FQHC NETWORKS

FEATURE	NUMBER OF NETWORKS (N = 8)
STRUCTURAL FEATURES	
Year Formed	
1991-1993	1
1994-l 995	4
1996-1997	3
Start-Up Funds	
ISN grant	6
Hospital funds	3
Foundation or other support	4
Tax Status	
For Profit	2
Not For Profit	6
Number of Network Members	
l-6	1
7-10	4
11-17	3
Number of Non-FQHC Members	
0	2
l-4	4
5-9	1
10 or more	1
Proportion of Non-FQHC Members	
0- 10 percent	2
1 l-25 percent	2
26-50 percent	3
51 percent or more	1
Formal Hospital Affiliations	4
Formal MCO Affiliations	2
Member Representation	
Equal for all	4
FQHCs have more representation	1
Rotates annually	1
Based in part on level of investment	2

TABLE IV. 1 *(continued)*

FEATURE	NUMBER OF NETWORKS (N = 8)
Service Area	
City or subcity	1
county	4
Multi-county	1
Statewide	1
Stage of Network Activities	
Planning/Early implementation	4
Intermediate	1
Advanced implementation	2
Defunct	1
MANAGED CARE INVOLVEMENT	
Network Contracting	
Any	6
Medicaid	4
Medicare	1
Commercial	2
Network Contracts Require Provider Exclusivity	
Medicaid	4
Medicare	3
Commercial	2
Supportiveness of Environment Toward FQHCs	
More supportive	4
Less supportive	4

1. Structural Features

Funding. The Bureau of Primary Health Care's Integrated Services Network (ISN) program provided important start-up funds for all but two of the eight networks, including two for-profit entities that relied on ISN funds for start-up capital. While the ISN funds provided important seed money, networks that received these grants have also needed to secure additional funding for start-up and/or ongoing operations. These other funding sources included support from network-affiliated hospitals, regional primary care associations, foundations, and other grants. Of the two networks that were formed in the absence of ISN funds, one received support from its partner hospitals and the other received substantial foundation grants.

Membership. The networks varied in the number and types of members they involved. Most had at least 7 members and in all but one FQHCs dominated the membership. A few networks included non-FQHC primary care providers, typically free clinics and similar entities that share the mission of serving the poor and underserved. About half included one or more hospitals as formal members, and two also affiliated formally with managed care organizations.* Those networks without formal affiliations with hospitals and/or MCOs require regular dues of their member health centers. (In some cases these dues are paid to a larger FQHC coalition that in turn supports the network in addition to traditional support and advocacy efforts). Only three networks are now open to new members; the remainder are working to solidify their current member base and/ or to focus on other aspects of network development before accepting new members.

Tax Status and Affiliations. Most of the networks have a not-for-profit status. The two for-profit networks formed recently and are operating in the same market. This market area is

[2] More formal relationships are defined as those involving some type of written agreement and/or financial contribution.

characterized by low levels of state support for FQHCs, the dominance of several large hospital systems, and moderate/high levels of competition for Medicaid, Medicare, and commercial managed care enrollees. Both networks are involved in Medicaid-only joint ventures between FQHCs and other historic providers of care to the underserved, large hospital systems, and insurer/managed care organizations (MCOs). The MCOs provided most of the network capital and met state licensure requirements for Medicaid contracting. The interest of hospitals and insurers in seeking formal affiliations with FQHCs in this market was at least partially driven by a component of the state's Medicaid 1115 demonstration waiver that requires inclusion of historic Medicaid providers. The manner in which the networks are incorporated protects the non-profit status of member FQHCs while allowing the network entities to function as for-profits.

Service Areas. All but one of the networks is essentially local in nature. This local emphasis most likely reflects historic affiliations among network members as well as the greater likelihood of developing a mutually beneficial strategy among entities facing the same market conditions. Only one of the networks (a for-profit entity with a deep-pocketed MCO partner) has a statewide service area; it plans to subcontract with non-members in other delivery systems to ensure adequate statewide coverage. Another network spans multiple counties, although most of its membership is concentrated in two urban areas. The other for-profit network will operate in certain parts of a large metropolitan area. The remaining four active networks are county-wide.

Network Activities. While some of the networks regard themselves and operate strictly as managed care business ventures, others are also engaged in more traditional FQHC collective efforts such as advocacy. All of the networks expressed interest in streamlining and centralizing operations across their members to improve member cost-efficiency. Typically the more advanced networks had introduced or, were soon to introduce centralized management information system (MIS)

capacity, and/or shared laboratory, pharmacy, or radiology services across member centers; less advanced networks planned or hoped to implement such efforts in the future. More advanced network activities also included focusing on managed care contract-related support such as quality improvement and utilization management, marketing, customer service training for member center staff, and developing the capability and funding to operate as a Management Services Organization (MSO). Networks at less advanced stages were more involved in hiring staff, developing legal and actuarial expertise, and working on basic member education and member support.

2. **Managed Care Involvement and Contracting Strategies**

Of those networks that have advanced to the stage of managed care contract development (six of the eight), all but one have established themselves as contract holders for their members. To date, four of the eight networks have successfully negotiated and hold Medicaid contracts. Additionally, one network has a commercial risk contract and is working on obtaining a Medicare risk contract. Two other networks hold a commercial and a Medicare contract, respectively. The single network that has opted to serve as a contract negotiator (versus holding the contracts) is in the process of developing a MSO joint venture with a member health center. The two networks without contracting strategies include the single defunct network in our sample and a less mature network that has not yet gotten to the stage of developing a managed care contracting strategy. Larger members (more than 10,000 annual users) were more likely to recognize and seek out the benefits from managed care risk contracting (because of their greater ability to assume and manage risk), and to be willing to sacrifice some autonomy for the sake of the network. However, smaller centers in networks were more likely to benefit from a collective approach to resource allocation and to have fewer alternatives in the absence of network membership.

Exclusivity provisions are an important component of long term contracting strategies for the networks in our sample. All of the operational networks that hold contracts centrally require or plan to require their members to contract exclusively through the network for Medicaid, commercial and/or Medicare contracts. One of the networks, however, requires Medicaid contracting exclusivity but has allowed certain members with more managed care expertise to contract individually for commercial and Medicare risk contracts, to ensure that it did not lose these stronger members. These individual contracts will be converted to network-held contracts when other members can meet commercial and Medicare contracting requirements. Some networks had also devoted substantial time and resources to gaining buy-in from FQHC members and to educating member centers and their individual boards about the value of giving up some autonomy in the interest of a strengthened collective approach to contracting.

Nearly all of the entities are early on in their contracting experience and are hard at work to improve their contracting positions and to develop optimal strategies for ensuring the sustainability of their networks and the survival of their FQHC network members. Only one of the networks reports having successfully negotiated a contract that places some members at risk for all professional care. Not surprisingly, this network is the most advanced of all those visited. Two other networks with members now operating under less favorable contracts (primary care risk only) hope to move to at least one full professional risk contract for at least some of their members in the coming year and are preparing themselves for intensive rounds of negotiations with MCOs. The other networks are considerably further behind in moving toward full-risk contracting. One network reports low levels of member interest in moving to assume risk under their managed care contracts. This network operates in a state with an historically high level of support for FQHCs and special

FQHC-related provisions that have reduced the pressures on FQHCs to take on more managed care risk.

Only one of the networks has had to confront the issue of how to divide managed care savings under network-held contracts between the network and its members. A few networks noted that this will be a difficult issue to gain consensus on among members, in that some would prefer to receive the surplus money directly rather than having it earmarked for network activities. For the two for-profit networks, the distribution of profits to FQHC network members appears to reflect varied levels of success in the negotiations with the hospital and MCO partners. In one of the networks, most of the profits will go to the hospital and MCO partners, while in the other network FQHCs will receive half of any profit distribution.

B. DECISIONS ABOUT NETWORK FORMATION AND HEALTH CENTER PARTICIPATION

The study FQHC networks and their member health centers provided the following insights about why they decided to pursue a network strategy:

- To respond to Medicaid program changes that were reducing fee-for-service options and threatening health center market share
- To gain access to more and better types of contracts, including (for some) contracts that included expanded risk-sharing arrangements
- To gain additional bargaining strength by working collectively with other health centers, and avoid being "shut out" by MCOs unwilling to contract with them
- To develop centralized information systems, utilization management, and other managed care-related support
- To allow member health centers to focus on their role as providers rather than competing with insurers, and ensure that health center patients would continue to have access to providers who understand and are skilled in meeting their unique needs

- To enable member health centers to enhance their managed care capabilities on an incremental basis without taking on the additional risk associated with forming a plan

Only one of the networks formed without any intention of competing for traditional Medicaid populations. In addition to focusing on Medicare risk contracts, this network is developing a managed care product to serve formerly uninsured populations under the expansion component of a pending Medicaid waiver program. Most of the networks aim in the long-term to reduce their dependency on Medicaid enrollment by gaining Medicare and commercial contracts, which they also hope will help bolster their members' ability to meet the needs of the uninsured and underserved.

Although half of the networks initially considered developing an HMO, more of them are now working toward or considering developing the capability to serve as an MSO or similar entity. Of the four networks that originally considered pursuing an HMO strategy, two have received licenses but only one is planning to become operational.[3] In contrast, two networks are actively developing or already have an MSO, and another three networks are contemplating developing an MSO in the future. This change reflects the recognition among the networks and their members that (1) forming and operating an HMO is very capital-intensive and beyond the reach of most entities without major "strings attached" capital infusions, which could in turn weaken the network's control over its mission and strategy, and (2) HMOs face real challenges in gaining sufficient market share in both established and emerging managed care markets. Furthermore, network members recognize that HMOs are risky ventures for entities without extensive risk management and managed care operational experience, and that this approach would involve a more abrupt transition to managed care for network members. In contrast, network members perceive the MSO option as significantly

[3] The network mentioned earlier that will enroll a previously uninsured expansion population under a new Medicaid 1115 waiver program.

less capital intensive, offering a more gradual transition to managed care, and providing the advantages of a collective strategy while allowing members to focus on their provider role and mission of serving the poor and underserved.

In some cases, health centers viewed the network option as the only means to overcome unsupportive state environments and local market conditions. This perception was most common among smaller centers and those with less managed care experience who would have greater difficulty negotiating favorable managed care contracts on their own. In general, smaller health centers valued networks most for their help in collective contracting and centralizing resources and expertise.

Health center views about network strategies varied most on the subject of risk-bearing. Some health centers strongly favored developing the network's capacity to secure expanded risk-bearing contracts for some or all of the members; others were against this approach and, instead, wanted the network to focus on providing administrative and management support (including assistance with the contracting process) and/or working gradually to develop health center capabilities to assume more risk.

Several of the study health centers had either opted out of a network or were planning to do so in the near future. Two had concerns about plans to centralize information systems, in part for confidentiality reasons but mainly because they thought the network lacked the expertise to handle such a complex endeavor. Others felt they could do just as well or better on their own, one noting that their contracts had stronger payment provisions and were secured more quickly than those negotiated by the network.

C. ATTRIBUTES OF MORE SUCCESSFUL NETWORKS

All of the networks visited are still developing and only preliminary information is available to judge their current success. Nevertheless, we saw some networks that seemed well-positioned to respond to opportunities in their local marketplace or were putting in the necessary infrastructure and capacity to do so in the future. We also visited several networks that seemed to be further away from successful operation and faced obstacles that made the likelihood of their future success a lower probability.

It is important to keep in mind that success at the network level will not always translate into success for individual members. Most of the networks emphasized that even if they are successful, there was likely to be some amount of shake-out (closures, mergers, shifts from the network to other types of affiliations) among individual members. Some of the more advanced networks were trying to ensure against the future failure of their members, particularly the weaker members, by helping them to analyze and reduce their costs, reduce emergency room utilization rates, and become more customer-focused to attract and retain more insured users. However, networks are less able to address problems such as a health center's location, size, and patient mix, and the condition and reputation of its facilities.

Attributes of networks that appeared to be responding more successfully to managed care are described below and summarized in Table IV.2.

- ***Making progress toward gaining favorable managed care contracts with*** the state and/or with MCOs
- ***Supported by most of the members***
- ***Implementing more advanced operational activities*** to support their members. Networks that combined their managed care-related efforts with more traditional

TABLE IV.2

ATTRIBUTES OF MORE PROMISING NETWORKS

CHARACTERISTICS	NUMBER OF NETWORKS MORE PROMISING (N = 4)	LESS PROMISING (N= 4)
Hold, or likely to gain in future, favorable risk-based contracts	3	0
Supported by most members	4	1
Implementing more advanced operational activities	3	0
Making progress in efforts to become self-sustaining	3	1
Members mostly similar in size	3	1
Members mostly similar in financial stability	3	0
Members predominantly FQHCs	4	1
Members have a history of working together	4	1
Stable leadership (no significant turnover)	4	2
Strong managed care expertise among staff	4	1
At least one member with strong managed care expertise and good relationships with other members	3	1
More supportive state/local environment	1	3

advocacy and technical assistance activities were typically less advanced in managed care areas.

- ***Trying to become self-supporting*** and/or to secure outside funding for future operation.

- ***Comprised of members with similar characteristics, the*** most important being size (volume of patients and revenue), financial health/capacity, and FQHC status (i.e., fewer non-FQHC members).

- ***Comprised of members who have worked together before,*** and are willing to sacrifice some autonomy to enhance the network.

- ***Having stable leadership (few transitions) and capable leaders/staff.*** In addition to having managed care expertise, network leaders need to understand the unique mission, capabilities and constraints of FQHCs members.

- ***Involvement of at least one more advanced "alpha "member. This*** member can serve as an important source of information and assistance to the network staff as well as to less advanced network members. This member will be less likely to be perceived as a threat or too dominant if they have already established good working relationships with the other members and demonstrate a clear willingness to serve as a resource for the other members. Networks with more than one more advanced member, however, need to be careful; one of the study networks struggled initially because of rivalry between two "alpha" member centers who had different visions for the network. More successful networks were open-minded about allowing more advanced members to pursue certain contracts individually when the limitations of other members prevented the network from negotiating such contracts for all the members.

- ***Less supportive environments. The*** networks in less supportive environments have identified and taken advantage of market-specific opportunities to compensate for their lack of official support. One network pursued group purchasing opportunities to build reserves to support its members, and recently won foundation support to launch its MSO activities, through which it hopes eventually to become self-sustaining. Three other networks in less supportive environments are affiliating with institutional providers; two have affiliated with hospital systems and MCOs to gain capital and entree to managed care contracts, and a third has affiliated with several hospitals and mental health centers and is developing MSO capabilities. These experiences suggest that FQHCs in less supportive environments may be more aggressive about seeking new opportunities, and that even in less supportive environments, FQHCs are considered desirable partners for hospitals and MCOs.

All of the networks are young and face an uncertain future. Most were formed to respond to anticipated or perceived inroads in Medicaid managed care and as a result are vulnerable to future

changes in the Medicaid managed care programs in their markets such as rate reductions, changes in the number and types of Medicaid-serving plans, and changes in state Medicaid managed care contract requirements. Additionally, networks trying to increase their Medicare and commercial contracting will face challenges in the future as these sectors evolve.

V. HOW THE HEALTH CENTERS ARE FARING

This chapter examines how individual health centers are faring and their current outlook under Medicaid managed care. Our findings are based primarily on site visit interviews with health center executives at 24 health centers; for the 22 health centers that receive federal primary care grants, we also analyzed annual report data from the Bureau of Primary Health Care on users, revenues, and managed care involvement.[1] The health centers were selected largely because of their link to an FQHC plan or network; in a few markets we also visited with health centers that had decided against the plan or network approach.

Our analysis sought to address the following questions:

- How similar or different are the health centers that participate with FQHC plans, and those in FQHC networks? How do these health centers compare with those that opt against these approaches?
- Which health centers appear to be facing greater obstacles surviving in a managed care environment, and how do they compare with the health centers in stronger positions?
- Do health centers that participate in an FQHC plan seem to fare better or worse than those in a network and/or those that opt against either of these approaches?

As was true for the study plan and network entities, health center strategies were still evolving at the time of the visits, in large part because of changes still occurring in Medicaid managed care programs and the health care marketplace overall. In many of the markets, health centers were quite literally facing changes on an almost daily basis. Consequently, while our findings convey a sense

[1] Two of the health centers are FQHC "look-alikes" and not required to submit these reports. For these health centers we had partial data and only for the most recent time period.

for health center experiences and strategies at a particular point in time, conclusions reached a year from now may be different. Adding to this is the fact that many of the FQHC networks and 2 of the 4 plans we visited were not yet fully operational, limiting our ability to draw conclusions about the influence of plan and network involvement on health center outcomes to date.

A. OVERVIEW OF STUDY HEALTH CENTERS

The study health centers varied in size and other operational areas but most had been involved in managed care for some time (see Table V.1). Consistent with the study's focus and selection criteria, most (80 percent) were involved with an FQHC plan or network (health centers in two markets were involved in both), with more than two-thirds (17 of 24) participating in an FQHC network. Only 3 health centers were not participating in managed care, outside of their involvement in primary care case management (PCCM) programs. Two others had committed to contract with an FQHC plan but the plan had not started operating in their service areas. Half of the centers had been participating in managed care for at least 5 years, and 8 centers had more than 10 years of managed care experience. At the time of our visits, the majority were involved in at least 2 Medicaid managed care contracts and over half (13) also held at least one Medicare or commercial contract. In 1996, 19 had at least some users in capitated managed care, typically 30 percent or less of their total user population.

Most of the health centers serve fewer than 20,000 users annually; 9 serve fewer than 10,000, and 4 serve more than 30,000. Nearly two-thirds reported having information systems that were inadequate to support managed care, including all but two of the smaller centers. Among these are some centers that are working with their local FQHC network to develop and support centralized

TABLE V. 1

CHARACTERISTICS OF STUDY HEALTH CENTERS

CHARACTERISTIC	NUMBER OF HEALTH CENTERS
Total	24
MANAGED CARE INVOLVEMENT	
Involvement with FQHC Plan or Network	
Plan only	2
Network only	10
Both network and plan	7
Neither but contract with MCO(s)	2
Not involved in managed care	3
Years of Managed Care Contracting	
None	3
<1	6
1-4	3
5-10	4
10+	8
Current Number of Medicaid Managed Care Contracts	
0	5
1	4
2	11
3+	4
Hold One or More Medicare or Commercial Contracts	13
Percent of patients in capitated managed care, 1996	
None	5
1-20	6
20-30	7
Over 30	6
OPERATIONAL FEATURES	
Total Users/Patients, 1996	
Under 10,000	9
1 o,ooo-20000	6
20,000-30000	5
Over 30,000	4
MIS capacity	
Adequate/strong	9
Weak	15

TABLE V. 1 ***(continued)***

CHARACTERISTIC	NUMBER OF HEALTH CENTERS
Total	24
Physicians follow patients in hospital?	
Yes, all	6
Yes, some	11
No	7
Accredited?	
Yes	5
In works	10
No	9
REVENUES	
Proportion of patients who are uninsured, 1996	
Under 30	6
30-50	11
50-70	5
Over 70	2
Proportion of revenue from grants, 1996	
Under 50	11
50-70	9
Over 70	4
Proportion of patients insured by Medicaid, 1996	
Under 20	6
20-40	12
Over 40	6
Proportion of revenue from Medicaid, 1996	
Under 20	9
20-40	11
Over 40	4

information systems. Although the majority of health centers said their physicians follow patients in the hospital, one-third reported having had significant problems obtaining hospital privileges and/or persuading their physicians to take on these additional duties. One striking indication of managed care's influence to date is that nearly two-thirds of the study health centers are in the process of becoming accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or have already obtained it.

With few exceptions, the study health centers depend on Medicaid and grant funding for the majority of their revenue. In 1996, the uninsured comprised more than one-third of the patient population for the majority of health centers in our study; for 8 of the study centers more than half of all patients were uninsured. This care is financed largely with grants from federal, state and local sources; grants comprised more than 50 percent of total health center revenue for the majority of health centers in our sample. On average 30 percent of the study health centers' patients in 1996 were insured by Medicaid, and Medicaid comprised a slightly lower percentage of total revenue for most health centers.

B. STRATEGIC RESPONSE TO MANAGED CARE

Although decisions about whether and how to participate in managed care varied and were influenced by a variety of factors and unique circumstances, all the health centers had actively decided on some sort of strategy (including in some cases a decision not to participate) and they had considered the pros and cons of different approaches. This alone indicates that the health centers consider managed care as something "to be reckoned with" rather than ignored, and that they are thinking strategically about the best ways to ensure the health center's survival in a more competitive

environment. Health center strategies related to FQHC plans and networks are discussed in Chapters III and IV; below we describe other changes and responses to the expansion of Medicaid managed care.

Alliances with non-FQHC plans and hospital systems. Even in the two markets where an FQHC plan currently dominates the Medicaid managed care market, health centers are formalizing relationships with other types of plans and with selected hospital-based medical centers. Members of FQHC networks are also trying to secure contracts with multiple plans and to solidify strategic partnerships with secondary and tertiary care providers. Health centers expect to benefit from these alliances in two primary ways: (1) protecting their medicaid patient base and revenues, and (2) generating funds for infrastructure and operational improvements. Many health centers had expanded or built new sites and/or implemented new information systems with funding from area hospital systems. Described as a "win-win" situation, the health centers reportedly benefit by having stronger facilities to attract and retain patients, the hospitals benefit from having a stronger (and presumably more "loyal") primary care "partner," and both benefit from improved systems for generating and sharing managed care and patient care information. These relationships also reportedly benefit patients, particulary the uninsured, because the hospital partners may provide secondary and tertiary care that would otherwise not be available. Potential drawbacks to these alliances, however, are that health centers may need to sacrifice relationships with other hospitals, and/or they may become too dependent on or beholden to their institutional partner(s).

Health centers are facing greater difficulties keeping their Medicaid patients because of the shift to mandatory enrollment in risk-based plans, the use of central enrollment brokers, and new rules for making default assignments. Consequently, many have decided to strengthen their position by

securing contracts with multiple plans. In addition to contracting with multiple Medicaid plans, 13 health centers hold at least one commercial or Medicare contract.

Adding ancillary services and/or urgent care capabilities. To position themselves more competitively, several health centers recently started providing radiology, pharmacy and other ancillary services on site. Several health centers are also adding urgent care capabilities. Often the urgent care component is being staffed by a hospital partner, and operates as a separate component outside of the health center's core "scope of project." Another health center expanded the operating hours of its existing urgent care facility to help further discourage emergency room use. A few health centers also mentioned adding other types of services, such as health education, mental health, and dental care.

Expanding sites, operating hours and/or after-hours coverage. Nine of the health centers have expanded their operating hours, and four of them also improved their after-hours coverage. Seven health centers added or expanded their sites in the past couple of years.

Streamlining management of patient care. Several health centers mentioned improving the way walk-ins are handled (e.g., designating certain staff to handle walk-ins, opening special walk-in clinics). Others have implemented training programs for physicians and other provider staff designed to improve their understanding and acceptance of managed care requirements. Several health centers also mentioned changing their referral patterns because of new managed care alliances, and several others have added staff to handle referrals and paperwork related to managed care. One health center replaced most of its managers to bring on people with expertise in managed care.

Some have had to cut back on services and/or operating hours. Six health centers mentioned that they have already reduced or plan to reduce the level of transportation, outreach and case

management services they provide because responsibility for these services has shifted to health plans under Medicaid managed care. Another health center has started using group sessions rather than individual contacts for case management because of financial constraints. Three health centers said they cannot afford to increase their hours despite the need, two have had to decrease their hours because of financial problems, and one has had to close a site because of building and code deficiencies that it could not afford to fix.

C. COMPARISON OF CENTERS THAT PARTICIPATE IN FQHC PLANS, IN NETWORKS, AND IN OTHER WAYS

We found few notable differences in the characteristics of health centers across different managed care participation strategies (see Table V.2). This suggests that it is difficult to predict the approach a health center should take based on any predetermined set of characteristics. The table compares features of health centers that participate in Medicaid managed care: (1) only with an FQHC plan, (2) only with an FQHC network, (3) with both an FQHC plan and a network, (4) by contracting with managed care organizations on their own, or (5) not at all. The approach a health center selects does not appear to be related to their years of managed care experience, their size (number of patients), their role in hospital care, accreditation status, or the proportions of health center patients insured by Medicaid or in capitated managed care. The few (weak) differences across participation approaches include (1) health centers participating in a network appear more likely to hold multiple Medicaid contracts, and many also have at least one Medicare or commercial contract; (2) health centers with more capable information systems are in a network or at least engaged in some form of managed care contracts; and (3) both of the health centers with very high percentages of uninsured patients are involved in plan or network arrangements.

TABLE V.2

COMPARISON OF HEALTH CENTERS BY MEDICAID MANAGED CARE PARTICIPATION STRATEGY

	NUMBER OF HEALTH CENTERS BY MEDICAID MANAGED CARE PARTICIPATION APPROACH				
CHARACTERISTIC	ONLY WITH AN FQHC PLAN N=4	ONLY IN AN FQHC NETWORK N=9	WITH BOTH AN FQHC PLAN AND A NETWORK N=4	NEITHER BUT CONTRACT WITH MCOS N=4	NO INVOLVEMENT N=3
Years of Managed Care Contracting					
None	1				3
<1		2	1	2	
1-4		1	1	1	
5-10		3	1		
10+	3	3	1	1	
Current Number of Medicaid Managed Care Contracts					
0	1			1	3
1	2		1	1	
2	1	5	3	2	
3+		4			
Hold Medicare or Commercial Contract(s)	3	9	1	0	0
Total Users/Patients, 1996					
Under 10,000	2	4		1	2
1 o,ooo-20000	1	2	1	1	1
20,000-30000		3		2	
Over 30,000	1		3		
MIS capacity					
Adequate/strong	1	5	1	2	
Weak	3	4	3	2	3

TABLE V.2 *(continued)*

CHARACTERISTIC	NUMBER OF HEALTH CENTERS BY MEDICAID MANAGED CARE PARTICIPATION APPROACH				
	ONLY WITH AN FQHC PLAN N=4	ONLY IN AN FQHC NETWORK N=9	WITH BOTH AN FQHC PLAN AND A NETWORK N=4	NEITHER BUT CONTRACT WITH MCOS N=4	NO INVOLVEMENT N=3
Proportion of patients who are uninsured, 1996					
Under 50	3	7	4	3	3
SO-70		1		1	
Over 70	1	1			
Proportion of revenue from Medicaid, 1996					
Under 20	3	3			2
20-40	1	5	2	3	1
Over 40		1	2	1	

There are more similarities among the health centers that had not yet participated in managed care. These 3 health centers are smaller, lack adequate MIS capacity, are not accredited, are funded largely by grants, and for two of them Medicaid comprises a smaller portion of their funding than the proportion of Medicaid-insured patients.

D. ATTRIBUTES OF HEALTH CENTERS RESPONDING MORE SUCCESSFULLY TO MANAGED CARE

Based on a combination of quantitative and qualitative data, we distinguished study health centers that appear to have responded more successfully and/or to have better future prospects under managed care. In addition to "hard" data on health center characteristics and recent trends, our assessment drew heavily on qualitative information and the insights and observations of the site visit team. The process for identifying more successful health centers consisted of two steps. First, we analyzed trends in the following variables for the 1993-1995 and 1995-1996 time periods:

- Total user volume
- Total revenue
- Medicaid revenue
- Share of total revenue from Medicaid
- Net income under managed care contracts

For each health center we noted the variables and time periods where there had been a decline. Then we drew upon qualitative information from the site visits and insights from the site visit team to refine the list of more and less vulnerable health centers.

Notably, all but one of the health centers had experienced declines in at least one of the quantitative variables we examined, and many had experienced a decline in all five variables for one or both time periods. Furthermore, although we lacked quantitative data to document trends related to the uninsured, nearly all of the health centers told us that they have experienced an increase in the volume of uninsured patients in recent years. Some of this increase was attributed to existing patients losing Medicaid and other insurance coverage, but health centers also reported an increase in the number of new patients lacking insurance. These findings alone suggest that health centers are facing increased pressures, at least those located in more advanced managed care markets like those included in our study. The trend data also suggest that the study health centers collectively faced greater pressures during 1996 than in the 1993-1995 time period. This is probably because more aggressive Medicaid managed care models had not been implemented until 1996 or later in most of the study markets.

In all, we determined that 11 of the 24 study health centers had faced greater difficulties to date and were in a more vulnerable position to contend with managed care-related pressures and opportunities in the future. We then compared key features of the more and less successful health centers to identify any factors that might distinguish the two groups (see Table V.3). For many of the features we examined, including whether the health center participates in an FQHC plan or network, the two groups appeared to be similar. However, we would expect to observe only weak differences associated with plan and network involvement for the study health centers because most of the networks and 2 of the 4 plans were not fully operational during the study time period.

In general, health centers with more successful experiences and prospects under managed care shared the following attributes:

TABLE V.3

ATTRIBUTES OF HEALTH CENTERS RESPONDING MORE AND LESS SUCCESSFULLY TO MANAGED CARE

CHARACTERISTIC	NUMBER OF HEALTH CENTERS (N=24)	
	LESS SUCCESSFUL (N=11)	MORE SUCCESSFUL (N=13)
Size of patient base		
Small (under 10,000)	6	4
Medium (1 O,OOO-20,000)	5	
Large (Over 20,000)		9
Managed care attitude and expertise of health center leadership		
Asset	3	13
Weakness	8	
Condition of Facilities		
Excellent/new or refurbished	3	6
Adequate	4	7
Inadequate	4	
Involvement with FQHC Plan or Network		
Plan Only	3	2
Network Only	5	4
Both Plan and Network	1	3
Neither	2	4
Change in operating hours		
Increase	5	7
Decrease	0	1
Proportion of patients who are uninsured, 1996		
Under 30	3	4
30-50	4	6
Over 50	4	3
Proportion of revenue from grants, 1996	1	5
Under 30	5	2
30-50	5	6
Over 50		
Proportion of patients in capitated managed care, 1996		
None	3	1
1-20		6
20-30	3	2
30+	5	4

TABLE V.3 *(continued)*

CHARACTERISTIC	NUMBER OF HEALTH CENTERS (N=24) LESS SUCCESSFUL (N=11)	MORE SUCCESSFUL (N=13)
Supportiveness of State/Local Environment for FQHCs		
More Supportive	4	6
Less Supportive	7	7
FQHC Reimbursement		
Reconciliation from state	5	4
Through plans	4	8
No special payment provisions	2	1
Decline in Users		
1993-1995	5	1
1995-1996	3	4
unknown	1	1
Decline in Total Revenue		
1993-1995	1	3
1995-1996	3	4
Unknown	1	1
Decline in Medicaid Revenue		
1993-1995	4	4
1995-1996	4	6
Unknown	1	1
Negative Net Income Under Managed Care		
1995	3	2
1996	6	6
Not applicable	3	2
Increase in share of revenue from grants		
1993-1995	6	2
1995-1996	4	9

- ***Larger. The*** more vulnerable health centers all have fewer than 20,000 users, whereas 9 of the 13 more successful health centers serve more than 20,000 patients annually. While size alone does not prevent a health center from losing patients and revenues, larger health centers are better positioned to shoulder these losses because of their greater "clout" in the market, because they often have reserves to draw upon during transitional or leaner times, and/or because they have more resources to direct to infrastructure and operational improvements.

- ***Capable leadership.*** We found that this factor may best distinguish more and less successful health centers. Several health centers had experienced major declines in Medicaid patients and revenues in large part because their leadership actively resisted involving the health center in managed care despite having the opportunity to do so. Others appeared to lack the expertise and skills for negotiating successfully with managed care organizations. On the other hand, several health centers had experienced substantial losses but faced better prospects because they were led by a skilled and knowledgeable executive director that was setting a promising course for the future. Even if the executive director lacks managed care expertise, they can still guide the health center effectively by hiring the right people to advise them.

- ***Adequate facilities and management systems.*** Many of the health centers we visited had recently expanded or renovated their facilities, in part so that they would be in a stronger position to forge relationships with managed care plans and/or hospital partners, and to retain patients and staff. In a few instances such expansions and other improvements have left the health center with a significant amount of debt, putting increased pressure on the health center to increase their revenues. On the other hand, those health centers with cramped and/or run-down facilities and management systems face greater obstacles surviving in more competitive markets. Some had upgraded their information systems to better support managed care needs. Many others are still operating with systems designed to support fee-for-service and grant funding environments. Poor information systems put health centers at risk of accepting capitation payments that are too low and/or limiting their ability to analyze and improve utilization patterns.

- ***Well-defined market niche.*** Although hard to define concretely, several health centers appear to be in a stronger position because they are recognized by patients, plans and other providers for their role and skill in serving particular populations. Some health centers are less vulnerable to declines in patient volume, for example, because their patients are quite loyal and are expected to remain with the health center despite pressures and opportunities from managed care. However, health centers that serve a significant number of immigrants worry that although they may retain the patient they may lose Medicaid financing for this care because of welfare and immigration reforms.

- ***Adequate funding for the uninsured.*** All but two of the health centers in our study receive federal funds for this care, but most health centers report that these amounts have not increased in step with increases in the volume of uninsured patients. Since virtually all of the health centers have experienced an increase in the number and proportion of uninsured patients, support from state and local sources (government, foundation, hospitals/other institutions) has become a very important factor in the survival of many health centers.

Overall, health center situations seemed to be influenced by a variety of factors that combine for each in unique ways. One health center, for example, has a very high proportion of uninsured patients and has resisted managed care contracting to date but they are likely to remain a strong and viable organization because they have a strong executive director, secure state and local funding sources, and a solid partnership with a local hospital system that is helping to subsidize care for the uninsured. This health center also expects to increase its Medicaid patients through an exclusive managed care contract with its hospital partner. In contrast, another health center is in a more vulnerable position because it has lost most of its Medicaid patients and revenues due to managed care, the executive director has resisted many managed care contracting opportunities, they are carrying significant debt from a recent move to a new facility, and they have very little financial support from state and local sources for the uninsured.

Although our findings suggest few general guidelines for how a health center' should participate in managed care, it seems clear that not participating at all is no longer a viable option. Even those health centers that had resisted managed care most adamantly in the past acknowledge that they can no longer afford to do so in the future. But among those who are participating successfully, some are part of an FQHC plan and/or a network while others have decided to participate in other ways. Rather, our findings suggest that the "right" approach will vary for each health center, and that health

centers must also assess whether the particular plan or network opportunity they face is the right one for them. Regardless of the specific approach taken, however, health center prospects are likely to be stronger if their leadership accepts and understands managed care principles, they have adequate facilities and information systems, and they have access to adequate funding for the uninsured.

VI. CONCLUSIONS AND POLICY IMPLICATIONS

In this chapter we summarize our conclusions and comment on the policy implications arising from this work.

A. CONCLUSIONS

Major findings from the study are organized into four sections that relate to the study's primary research questions.

1. How are FQHCs responding to and faring under managed care?

Overall, FQHCs are experiencing significant pressures from the expansion of Medicaid managed care and they are acting strategically in facing these challenges. Health centers recognize the importance of participating in managed care and even those who have held back to date will be participating in the future. In addition to becoming involved in FQHC plans and networks, many health centers are responding to managed care by strengthening ties with local hospital systems and by expanding their involvement in Medicare and commercial managed care contracts. Many (but less than half) have improved their facilities and operations: adding on-site ancillary services and urgent care capabilities, expanding their sites and/or operating hours, upgrading their facilities and/or information systems, and improving after-hours coverage and the handling of walk-ins, prior authorizations, and referrals. Several health centers, however, have had to make cuts: six have reduced or expect to reduce the level of enabling services provided, several have had to reduce or limit their operating hours, and one had to close a site.

Nearly all of the health centers in our study experienced a decline in users, revenues and/or net income under managed care since 1993, with more health centers experiencing losses during 1996 than in the earlier time periods. Also, most report having experienced an increase in the volume and

proportion of uninsured users. This suggests that, at least in more advanced managed care markets, health centers of all types are facing increased pressures related to managed care.

Regardless of how they are participating, most health centers are currently comfortable limiting their risk to primary care. Only a handful of the health centers we visited are currently interested in taking on additional risk tied to specialty and/or hospital care, although most welcome the opportunity to share in any savings that result from their management of this care.

Health centers in many of the markets, either alone or through their networks, are strengthening ties with local hospital systems as a means of survival under managed care. The hospital partners are providing capital for facility and information system improvements, and providing specialty and hospital care for the uninsured. But a potential downside to these partnerships is that the health centers may have to sacrifice relationships with other hospital systems and risk losing some of their independence.

2. **Why are some deciding to form plans and/or networks?**

The FQHC plans and networks we visited were all formed to respond at some level to expansions in Medicaid managed care (one will focus only on the expansion component of a new Medicaid waiver program). The network approach was selected by many primarily because it enables health centers to centralize contracting and other manage care-related supports, and to develop health center managed care skills more gradually. Furthermore, some health centers hope that the network will help them gain access to contracts involving more risk and the potential for greater financial benefit.

Those opting to form a plan were willing to take on more risk in exchange for greater control over and access to savings from strong care management. Key assumptions driving these decisions were that health centers would contribute a substantial number of Medicaid enrollees and would

manage care cost effectively. Many of the study networks had considered but rejected the option of forming an HMO. They cited the following drawbacks to forming a plan: (1) the start-up costs would be too high; (2) health center management and information system capabilities are inadequate to support such an approach; (3) it would be too difficult and risky trying to compete with large and established plans; and (4) health centers should focus on their role as a provider, rather than competing as an insurer.

3. **What factors cohtribute to- the success of FQHC plans and networks?**

While FQHC plans have succeeded in the past under favorable market conditions, they face major challenges in today's more competitive managed care markets. All the plans (like their competitors) are under increasing pressures arising from reduced premiums and increased competition for Medicaid enrollees. The two more established plans, dominant in their service areas, are responding to increased competitive pressure by broadening their provider networks and expanding into new areas and product lines. In addition to contracting with most FQHCs, both of the established plans also contract with a substantial number of non-FQHC providers for primary care. FQHC plans were encouraged to give strong consideration to including non-FQHC providers in their networks because this enables the plan to expand its capacity and/or service area, and to attract more commercial and other enrollees, enhancing the plan's long-term viability.

The newer plans face significant challenges getting established in some markets. Medicaid managed care markets today are generally more competitive, and the movement to mandatory managed care is happening more quickly than in the past. At the time of our visits it appeared unlikely that either of the newer plans would succeed in the study markets, which are the more competitive areas of the respective states.

Capital needs are a major concern for newer FQHC plans and those trying to expand into new areas or product lines. Although being not-for-profit fits with the mission and image of FQHCs, non-profit plans also face greater obstacles accessing critically-needed capital. Plans cautioned that before they can be self-sufficient they need to build a substantial enrollment base and to have providers that know how to managed care cost effectively. To succeed in more advanced managed care markets, newer FQHC plans are likely to require special support in the form of higher rates, preferences in contracting, or favorable enrollment policies.

The network approach appears to offer health centers significant advantages in more competitive markets, but developing and sustaining a network is hard work and requires significant resources and expertise. Most of the networks we visited are new and still developing their strategies and capabilities. Most are comprised of FQHCs and similar primary care providers, but a few also include hospitals and two are affiliated with managed care organizations. All are trying to secure managed care contracts for their members but only some are trying to expand the amount of risk assumed by member health centers. They are all also engaged to some extent in developing centralized administrative and operational support for member health centers.

Network success appears to be influenced mainly by factors internal to the network and its membership. Capable leadership and similarities in the size, FQHC status, managed care capabilities and goals of member health centers seem most important in determining success for the networks. Interestingly, it appears that stronger networks may develop in environments that are less supportive of FQHCs--perhaps because in these markets the incentives to pursue collective strategies are greater because of more threatening conditions at the state and local level.

4. **Do health centers participating in FQHC plans fare better than those in networks?** How **do these health centers compare with those participating in other ways?**

We found few differences between health centers participating in managed care as part of an FQHC plan, in an FQHC network, and as individual subcontractors. The manner in which an FQHC participates also does not by itself seem to have influenced how they have fared to date, but this may be because many of the plans and networks were not yet fully operational during the study period. More important factors thus far appear to be the health center's size or capacity, the managed care capabilities of its leadership, the adequacy of its facilities and systems, and the availability of funding for care to the uninsured, and/or having a more secure market niche (i.e., serving particular population groups and/or providing specialized services).

The information and operating systems of many FQHCs are not yet adequate to support managed care. The FQHC plans we visited noted that most of the FQHCs they contract with have very limited capabilities (expertise and systems) for conducting utilization review, provider profiling, and cost/payment analyses related to managed care. The plans have supported the health centers in these areas to the extent feasible, but they worry about their ability to sustain this support in the future.

Although FQHC plans are generally more committed to supporting FQHCs than other types of plans, increasing cost pressures have already started to limit their ability to do so as fully as they have in the past. Premium payments to FQHC and other Medicaid-serving plans were expected to decline in the future for all the plans we met with, which will in turn put a downward pressure on primary care payment rates and the dollars available from specialty and hospital pools.

Networks are expanding FQHCs' involvement with health plans, hospitals and other non-FQHC organizations. Although most of the networks want members to contract exclusively through the network, they are seeking contracts with multiple plans and expanding beyond Medicaid to seek

contracts with commercial and Medicare plans. Both smaller and larger health centers are benefitting from network efforts. But larger centers are more likely to be looking for opportunities to take on more risk, while smaller centers are more attracted to the benefits of collective contracting approaches and shared information and management systems.

B. POLICY IMPLICATIONS

Our findings have several implications for programs and policies designed to strengthen the viability and success of FQHCs under managed care.

First, policymakers need to think carefully about the way in which cost-reimbursement provisions are structured to ensure that they encourage cost efficiencies but do not discourage health plans from contracting with health centers. Medicaid cost reimbursement has contributed greatly to increasing health center involvement in and reliance on Medicaid. And despite important concerns about promoting cost inefficiencies, the policy has enabled many health centers to become better prepared to participate successfully in managed care. Future policy should encourage health centers to operate efficiently while ensuring that Medicaid revenues are adequate to cover the reasonable costs of this care. Requiring health plans to pay health centers higher rates may create disincentives for plans to contract with FQHCs and discourage health centers from trying to recover their costs from the plans. Approaches that allow health centers to reconcile directly with the state appear to best ensure that health centers are not placed at a disadvantage as they attempt to secure contracts and build enrollment with Medicaid-serving plans.

Second, it appears that FQHC plans face major challenges in today's markets, and they may not be able to sustain the same high levels of support to FQHCs in the future. This means that many of the health centers involved in FQHC plans will need to strengthen their internal information and management systems to support their involvement with other types of plans and reduce their reliance

on support from the FQHC plan. Furthermore, as the plans expand and broaden their provider networks, FQHCs are becoming less dominant in both the provider networks and governing boards for these plans. And although FQHC plans tend to be smaller than many of their commercial competitors, their Medicaid expertise and market share may make them attractive partners or acquisition targets in more competitive Medicaid markets

Third, although it is too soon to tell whether the networks we visited will succeed in some of their objectives, the network approach appears to offer some health centers key advantages over operating alone. Smaller health centers in particular benefit from network efforts to centralize managed care support (including contracting) and information/operating systems. Larger health centers see the network approach as a means of expanding the amount of risk/opportunities they can assume because the collective approach allows them to develop the resources and systems to support more advanced types of managed care arrangements.

Finally, in addition to concerns about primary care for Medicaid patients, health centers are facing increased pressures related to their role in serving the uninsured and in providing support services such as outreach, case management and transportation. Medicaid managed care reforms are reducing health center Medicaid revenues; for many, managed care payments are not covering the costs of primary care to their Medicaid patients. This, combined with increases in the number and percentage of health center patients lacking insurance, has put increased pressure on health centers to find additional support for or to cut back on the services they provide to the uninsured. In several of the markets we visited, local hospital systems are playing an important role in supporting care to the uninsured. Health centers are forming partnerships with local hospitals as a means of survival and to sustain services to the uninsured. But policymakers need to consider the effects of these partnerships on the health center's status as an independent and community-run organization. Some health centers have already made cuts in support services and others worry that they will have to do

so in the future. Health centers are concerned that their patients require more than the level of support services being provided and financed by managed care plans, but the health centers can't continue providing these services without additional funding..

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